LIBRARY OF THE UNIVERSITY OF MICHIGAN

THE MEDICAL NEWS AND LIBRARY.

VOL. XXIX. JULY, 1871. No. 343.

CONTENTS.

CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Digital Examination of the Uterus 97
Clinical Remarks on the Treatment of Orchitis 100
Clinical Remarks on the Treatment of Hæmoptysis 101
Diagnosis of Recent Endocarditis . . . 101

HOSPITAL NOTES AND GLEANINGS.

Operation for the Cure of Prolapsus Uteri . 102
Case of Uterine Hæmatocele 102
Cast of the Female Bladder 103

MEDICAL NEWS.

Domestic Intelligence.—Allopathy . . 104
Opium in the Treatment of Dysmenorrhœa . 105
Belladonna in Typhoid Fever 105
Hydrate of Chloral in Intermittent Fever . 105
Rupture of the Liver without External Evidence of Violence 105
Cundurango 105
Harvard University Medical School . . 106
The American Journal of Obstetrics, &c. . 106
The Virginia Clinical Record 106
Obituary Record 106

Foreign Intelligence.—Some further Additions to Therapeutics; Organic Bromides, Metachloral; with a note on Sulphur Alcohol 106
Neuralgia treated by the Constant Current 107
Treatment of Obstinate Vomiting by Iodine 108
The Nature of the Intestinal Lesion of Enteric Fever 108
Gastrotomy for Internal Intestinal Obstruction 109
Fatal Result from the Intra-Uterine Injection of a Solution of the Sesquichloride of Iron 109
Raw Meat 109
Ought Consumptives to Marry . . . 109
Pathology of Phthisis 110
Typhoid Fever with Constipation . . . 110
Dislocation of the Hip 110
New Fluid for the Preservation of Microscopic Preparations 110
Cholera in Madagascar and along the South-east Coast of Africa 111
Alkaloid detected by Picric Acid . . . 111
Deaths from Chloroform 111
Von Graefe's Successor 111
Oppolzer's Successor 111
Smallpox 111
Obituary Record 111

GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC., 16 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Digital Examination of the Uterus. By GRAILY HEWITT, M.D., Professor of Midwifery in University College, and Obstetric Physician to University College Hospital.

GENTLEMEN: I propose to speak to-day on a subject introductory to the study of the diseases of women—namely, the methods of examination which assist us in obtaining information with respect to those diseases. The difficulties in practice are not so much difficulties in regard to treatment as to diagnosis. Moreover, mistakes in practice are more frequently due to errors in diagnosis than to any other cause. The knowledge of the physical condition of the generative organs was formerly a matter very much of conjecture. Physical examination was only carried to a slight extent. True, ages past, some old physicians, such as Aetius, as was not long since pointed out in one of the medical journals, had been acquainted to a certain extent with the physical alterations of the uterus, which must have been derived from a careful examination by means of the finger. It is a fact, however, that until comparatively recent times the investigation of the physical condition of the generative organs was carried to a very slight extent.

Within the past thirty years much attention has, however, been given to this subject. For some time the speculum was the instrument almost exclusively used in obtaining information as to the physical condition of the uterus. This method of investigation has been followed, in too many cases, to the exclusion of all

Published monthly by HENRY C. LEA, No. 706 & 708 Sansom Street, Philadelphia, *for One Dollar a year; also, furnished* GRATUITOUSLY *to all subscribers of the "American Journal of the Medical Sciences," who remit the Annual Subscription, Five Dollars, in advance, in which case both periodicals are sent by mail free of postage.*

☞ *In no case is this periodical sent unless the subscription is paid in advance.*

other methods of examination. One cannot, therefore, be surprised at finding that in many instances very remarkable physical alterations of the uterus remained quite undetected, since the examination was confined to a visual inspection of the os uteri. It is, however, from digital examination of the uterus that we are able to learn most regarding the condition of the uterus. This is a point I am most anxious to impress upon you; and I now desire to explain to you how this examination is to be made, and what are the results to be expected from it. I was exceedingly pleased to find in a work recently published by M. Courty, of Montpellier, that the extreme importance of the digital examination of the uterus is so fully recognized. Unquestionably the speculum, and above and beyond that the sound, give completeness and exactness to the investigation in particular cases; but still the digital method stands first, and you will do well to recognize this as the primary one.

By means of the finger educated to the proper degree, you can become acquainted with the size and position of the uterus, the state of the vaginal canal, with the condition of the organs lying in the immediate vicinity of the uterus, the ovaries; with the presence of a tumour lying in the pelvis in the same situation, and affecting the uterus. You can make this examination by the vagina, or you can make it by the rectum. Another method consists in a sort of double examination, one finger being inserted into the vagina, and one or two fingers being placed over the symphysis pubis. When the patient is in a favourable position, you can get thus most important information. So also a double examination from the rectum and over the pubes can be made by placing one finger in the rectum and two over the pubes. You endeavour to bring the two together, and if the patient is not very stout or fat, you can do this in such a perfect manner as to make it absolutely certain, for instance, that there is no uterus in a case in which that organ is congenitally absent. Thus also you can determine the shape of the top of the uterus. In fact, there seems to be hardly any limit to the information that can be gained from it under tolerably favourable circumstances. Much, however, depends on the position in which the patient is placed, and by far the best position for such double examination is lying on the back, not on the side, with the knees drawn up, and the observer standing at the patient's right hand. The first or second finger of the right hand is then passed in as far as possible; then two fingers of the left hand are placed over the pubes, and pushed inwards and downwards into the pelvis. In this way the two fingers can be brought into close proximity, the abdominal walls being in this position completely relaxed.

I will next describe the digital examination of the vagina only. A proper position is very essential; and the only good one is for the patient to lie on the couch on her left side, with the hips close to the edge, and the knees drawn well up. It is quite impossible to make a satisfactory examination with the patient lying in the middle of a soft bed.

The examination is usually conducted by means of the forefinger of the right hand. To arrive at the aperture of the vagina, place the left hand upon the great trochanter of the patient, and immediately under that you will find the vulva. Remember the distinction between the vulva and the vagina. The former is nearly an inch in depth; and after passing on for that distance, the finger comes to the position of the hymen, the beginning of the vagina proper. If no impediment is created by the existence of the hymen, the finger of course passes inwards as far as the vagina extends; and the normal length of the vagina, including the part belonging to the vulva, is represented pretty exactly by the length of the forefinger, which has to pass in almost as far as it can be inserted before its tip reaches the cul-de-sac behind the os uteri.

Thus the first thing that is determined by this examination is the length of the vagina. That is determined at once. Next comes the condition of the uterus; and the facts relating to this must be set down under several heads.

The first point is the condition of the os uteri. Normally, in the woman who has

not borne children, the finger finds merely a small aperture. In women who have had children the aperture is generally larger, it may even be so large as to admit one or two fingers.

Next determine the length and shape of the cervix, and recollect that it really occupies nearly one-half of the length of the uterus. The part which can be felt by the finger in the vagina is, however, only a small portion of the cervix—the "vaginal part," as it is called; the greater part of the neck is above that. You have to determine the length of this vaginal portion. In women who have not borne children this is not more than half or three-quarters of an inch. It may be much longer, or it may be shorter, and the latter point becomes very important with reference to the diagnosis of pregnancy. The cervix is not really shortened in that condition, but it is drawn up out of the vagina so as to appear shorter.

Next the density of the vaginal part of the cervix has to be investigated. There is a considerable softness about it normally, and yet it is pretty firm. In pregnancy it becomes very soft, and in the latter part of pregnancy it becomes as soft as velvet, so that towards the end you have a difficulty in making out that there is an os uteri at all.

The symmetry of the os uteri should next engage your attention. Is it symmetrical in form? Is it symmetrical as regards density? Nodulation or cicatrisation is an important sign. In cancer, for instance, there is a complete loss of symmetry both as regards form and density; it is irregular in outline, nodulated often, harder than natural, and the increased density is always greater on one side than on the other.

If you are a beginner you will find that this part of the examination will occupy you at least several minutes. The more practice you have the more rapidly will you be able to determine these several points.

After thus investigating the condition of the os, you may next proceed to examine the neighbourhood of the uterus. This may conveniently be regarded under four divisions: (1) that in front of the uterus; (2) that behind it; and (3, 4) those on each side of it.

Commencing with the examination of the anterior region, the finger is pushed forwards and upwards in front of the neck. It displaces the vaginal wall before it, and can thus be made to rise to a considerable distance in the pelvis between the uterus and the bladder. You will readily understand that, if the uterus is bent forwards unduly, the finger will thus come upon it and touch it. So, also, if there is a tumour in front of the uterus, the finger will come upon it. Thus this examination will inform you of the presence or absence of a tumour there, or of anteflexion or anteversion of the uterus. Sometimes anteflexion will escape notice thus. The finger, being pushed forcibly up in front of the uterus, causes the organ, as a whole, to turn on its axis backwards, and you may fail to find the tumour because it retreats before the finger. The longer the disease has existed the more likely is this to occur, since after lapse of time the uterus gets rigid and fixed in its abnormal shape. This examination in front of the uterus will enable you to eliminate pregnancy. If a patient has arrived at the third month of pregnancy, you will certainly be able to detect the enlargement of the uterus; while if you can detect no tumour in front of the cervix you may be pretty sure that pregnancy does not exist. Pelvic tumours of various kinds are liable to be met with there. An ovarian tumour may be felt there. A tumour growing out of the uterus itself may be found there. Peri-uterine hæmatocele, consisting of an effusion of blood, may be situated in front of the uterus, and cause a hard and rather firm tumour in this position. In pelvic abscess and cellulitis there is an induration in the pelvis which may also be situated in this locality.

The neighbourhood behind the uterus is equally important with that in front of it; and its examination ought never to be neglected. When the uterus is in a proper position, the finger, passed up behind the cervix, is unable to explore the uterus higher than a point just above the junction of the vaginal wall and the cervix; and nothing can be felt beyond

that point. But we often do find a tumour in that situation. Its most common cause is retroflexion of the uterus; and then the finger comes upon the body of the uterus behind its neck. In all cases of retroflexion, except those in which the amount is very slight indeed, you will find a tumour there. Certainly, in ninety-nine cases out of a hundred you will be able to detect it. I have frequently known marked retroflexion to be missed solely from the practitioner neglecting to examine the part behind the neck, and confining the investigation to the condition of the os itself. Finding a tumour there, you have next to make out its shape; and the most important thing to ascertain is whether the tumour is symmetrical and in the middle line. The retroflexed fundus is usually, as might be expected, symmetrical, and generally nearly in the middle line. But the tumour may be due to other conditions: one of the ovaries may be displaced, and may lie near the middle line behind the uterus. It is not common; but the ovary may be found there, enlarged and painful. You would separate it from the uterus by making out that it was not continuous with the cervix. The point of the finger is made to travel slowly from one point to another; and, if it be an ovary, you find a break between the two. A fibroid tumour growing from the back of the uterus is not very rarely met with in this same position, which may be of any size, and may simulate very closely retroflexion of the uterus. The diagnosis between the two is made with the greatest possible ease by means of the sound. Sometimes a fibroid tumour is associated with retroflexion, and is, indeed, its cause, pulling the uterus back. Another tumour often met with there, is that caused by pelvic cellulitis. This is usually found to one side; it is hard, dense, and resistant in the chronic stage, and the parts are evidently all matted together. It is sometimes difficult to distinguish this tumour from one that consists of a fibroid tumour alone. Peri-uterine hæmatocele is more common in that situation than in any other.

By examining the lateral aspects of the uterus, you become acquainted with the condition of matters in the broad ligaments—the space which intervenes between the two surfaces of the peritoneum which are reflected over the Fallopian tubes, and inclose a dense mass of cellular tissue and an immense quantity of vessels, veins, arteries, and lymphatics. It is in this situation that inflammation so frequently occurs. If you suspected that a patient had pelvic cellulitis, you would, as a rule, expect to find the swelling on one side or other of the uterus. Tumours do not so often grow from the sides of the uterus as from the front and back, or at all events are not so obvious on a vaginal examination. Effusions of blood may also occur at the sides of the uterus. Sometimes the uterus is turned over to one side, giving rise to lateral version; and this is very commonly combined with anteversion. In retroversion it is common to find the uterus a little to one side of the middle line, but not so much as in anteversion.

Having thus examined the os uteri and the region round it on all sides, by means of the double examination I have before referred to, you may extend this, and render some things certain which before were uncertain.—*Lancet*, May 13, 1871.

—

Clinical Remarks on the Treatment of Orchitis.—In a clinical lecture on this subject, Mr. JONATHAN HUTCHINSON remarks (*Medical Times and Gazette*, April 22, 1871) that in that form of orchitis, in which the epididymis, body of the testis itself, the tunica vaginalis, and the cellular tissue of the scrotum, are all involved, gonorrhœa is the most common cause. In these cases the effusion is usually serum only, and a speedy and complete cure by absorption may be expected; but in exceptional instances suppuration may occur in the cavity of the tunica vaginalis, and, in others still more exceptional, in the body of the testis itself. Gonorrhœal orchitis almost always subsides spontaneously, and without any permanent damage to the gland. All that is necessary is to keep the patient in bed, to purge him freely, and apply ice to the part. Now and then, however, the severity of the inflammation may be such as to

threaten abscess, or even to cause gangrene. When the pain is intense, and persists, in spite of the use of ice, Mr. Hutchinson believes that the practice of making incisions is not only safe, but very valuable. Some surgeons, he observes, are in the habit, even in ordinary cases of gonorrhœal orchitis, of seeking to relieve tension by making one or more punctures into the tunica vaginalis, or even into the testis itself. He believes that it may be accepted as the result of their experience that such punctures seldom do any harm; to most surgeons, however, they scarcely appear to be necessary. In recommending incisions, Mr. Hutchinson states he is speaking rather of the exceptional states in which abscess is threatened; and, in looking back upon his own experience, he is certainly inclined to regret that in several cases he did not make incisions earlier. A free incision into the tunica vaginalis leads to no ill consequence whatever, and if it happens that pus is let out the relief is immense. A free incision through the tunica albuginea into the testis itself does not lead to gangrene of the testis, nor always even to fungous protrusion. When the testis is swollen, it appears to relieve pain much with the same certainty that iridectomy does the pain of acute glaucoma, and Mr. Hutchinson's impression is that it is likely in critical cases to diminish the danger of gangrene on the one hand, and of consecutive atrophy on the other.—*The Practitioner*, June, 1871.

—

Clinical Remarks on the Treatment of Hæmoptysis.—Dr. Waters, in a clinical lecture on this subject, stated (*Brit. Med. Journ.*, March 11, 1871) that when hæmoptysis occurs during the progress of a case of phthisis, no special treatment need be directed to it; should it be, however, at all severe, rest should be enjoined, and no risk run by which an inflammatory attack might be brought on. In regard to the various measures that are usually resorted to, he considers the best remedy to be used is gallic acid, as being the safest, the most rapid, and the most effectual. It should be given in full doses of not less than 10 grains every hour, or every two, three, or four hours, according to the severity of the case. It is readily taken by patients, it rarely disagrees with the stomach, and is well borne by delicate persons. It rapidly finds its way into the urine and is excreted. Acetate of lead, especially when combined with opium, is often of great service. He usually gives it in the form of pill, in two or three grain doses, every two, three, or four hours, but it should not be too long continued on account of its constipating effects. Sulphuric acid is a good remedy in slight cases of hæmoptysis, and it may be combined with other substances, as quinia and iron, which are given for the general treatment of the disease. It should be given in doses of from 10 to 30 minims. Dr. Waters' experience of the use of ergot of rye in pulmonary hemorrhage is not very favourable. In severe cases of hæmoptysis he always applies ice to the chest; it should be included in a bag, and not allowed to remain so long as to produce a chill. In regard to digitalis, as far as his experience goes, he is unable to recommend it as a trustworthy remedy in hæmoptysis. He occasionally prescribes dry cupping, but never fails to give styptics internally at the same time. He gives a caution against the indiscriminate administration of purgatives. Turpentine he considers to be less valuable in hemorrhage from the lungs than in hemorrhage from the bowels. The room should be kept cool and well ventilated; the food should consist of iced beef-tea and milk, and small pieces of ice given to the patient to suck.—*The Practitioner*, May, 1871.

—

Diagnosis of Recent Endocarditis.—Prof. Skoda observed (*Lancet*, June 3, 1871), in the course of some clinical remarks at the Vienna Hospital, with regard to a case of second attack of acute rheumatism, with a systolic murmur at the apex of the heart, that, though the mitral insufficience here present was a proof that endocarditis *had* existed, the question one should always consider, if a patient come under observation with an intra-cardial murmur and rheumatism side by side, is: "Is this murmur due to old or to recent endocarditis?" Where the history fails to help us,

we may be aided by remembering the following points: In a recent endocarditis the spleen will probably be plugged (infarcted) with fibrinous deposit from the valves, and therefore *enlarged*. Similar infarction of the kidneys will give rise to the presence of blood in the urine. Pains in the cardiac region, and irregularity and palpitations of the heart, if they exist, point to a recent endocarditis; but they depend more on the fever present than on the endocarditis *per se*. The most certain proof of fresh endocarditis is a gradual increase of dilatation of the heart during the course of the rheumatic attack, especially if followed by palpitations and dyspnœa.

HOSPITAL NOTES AND GLEANINGS.

Operation for the Cure of Prolapsus Uteri.—Dr. Graily Hewitt's operation for the cure of prolapsus uteri consists in removing from the perineal end of the posterior wall of the vagina a triangular portion of mucous membrane, of which the apex is towards the uterus, and the base at the posterior commissure of the vulva. In the present instance, an operation performed two months previously had succeeded so far as regarded the vaginal mucous membrane, but, union having failed to take place between the edges of the base of the triangular wound, the constriction of the vaginal orifice, which was the main object in view, had not been effected. Dr. Hewitt pared the edges of the posterior half of the orifice, and brought them together by means of two deep interrupted sutures of strong metal wire, and three superficial sutures of finer wire inserted within the deep ones. The deep sutures were secured by means of a small apparatus which Dr. Hewitt calls a "bead." It is made of ebonite, is gourd-shaped, and consists of a body and an expanding neck, of which the former is as large as a full-sized pea. When the suture is inserted, a bead is strung on at either end, with the neck outwards; and while it is pressed against the labium with one hand with the proper amount of force, it is fixed in position by winding round its neck, with the other, the projecting extremity of the wire suture. Dr. Graily Hewitt claims for the beads that, their action being more defined and local than that of portions of bougie, they have not the same tendency to maintain, in the included lips of the wound, a state of congestion which is unfavourable to healing, and has, in some instances, produced sloughing.—*Lancet*, April 29, 1871.

Case of Uterine Hæmatocele.—H. C., aged 39, is a widow, and has had no children. She was admitted to Ward 16, under Dr. Matthews Duncan's care, on February 16, complaining of pain and swelling in the lower part of her belly, and of pain at the base of the sacrum. About a fortnight before admission, after being exposed to the influence of cold and damp during menstruation, she caught a severe cold, which confined her to bed for some days. Her last monthly period began a fortnight ago; it lasted for three days only, her previous periods ending after an illness of a week's duration. On the day following this abrupt disappearance of the last menstrual flow, she noticed a swelling in her belly at its lower part, which was hard and painful. The size and hardness of, and the degree of pain felt in the tumour by the patient were increased next day. Her monthly periods had been previously regular.

On inspection, the belly is observed to be somewhat prominent, but presenting to the hand a natural feeling, except on the right side inferiorly, where a mass of hardness is felt, which rises as high as half way to the umbilicus. There is no particular tenderness or sensitiveness on touching this, and there is resonance everywhere over it. On examination per vaginam, the cervix is found to be nearly in its natural situation, uterus fixed. The pelvis is not occupied by the tumour, but in the plane of the brim there is felt fulness, and at the right side hardness.

The tumour above described gradually diminished in size, and on an examination being made three weeks after admission, a trace of it only could be detected.

Remarks.—It is almost inconceivable that a disease like the one at present under consideration, which must have existed as long as woman herself, should

have been recognized and described for the first time within the last twenty years. Long after its description, however, ignorance as to the nature of uterine hæmatocele prevailed in this country, and it is only recently that it has become at all widely known. One might ask—What did our predecessors make of such cases? They were, in all likelihood, mistaken by them for ovarian dropsies, fibroids of the uterus, etc., and their subsequent rapid absorption and disappearance were probably attributed to the potent deobstruent qualities of certain drugs, or cited as instances of the spontaneous cure of these diseases. An intimate connection between menstruation and the advent of a uterine hæmatocele is, in many cases, to be observed. On studying the history of the case before us, this point is well illustrated. The woman C., instead of remaining poorly for a week, as was her wont, menstruated for three days only, and it was, she tells us, on the day after the cessation of her menses that she first noticed the swelling in her belly. This fact is of importance, and holds good in the majority of cases of this nature. Another point of importance with regard to this disease is suggested by the discussion of the history of a case—namely, the origin of the blood which goes to form the hæmatocele. From whence does this blood proceed? The most common source is the mucous membrane of the body of the uterus, the place from which bleeding, in most cases of hemorrhage in connection with the internal genital organs originates. Doubtless, other sources exist, but this is the commonest one. The blood, issuing from the uterus through the Fallopian tube, discharges itself into the cavity of the peritoneum; there it excites some degree of perimetritis, which also produces adhesions, which contribute to inclose it. The site of a tumour thus formed must be of necessity within the peritoneum. Post-mortem dissections of cases fully corroborate this statement. The diagnosis of uterine hæmatocele is chiefly dependent on a consideration of the previous and subsequent history of the case. Its advent is characterized by suddenness, and, as has been already shown, is closely connected in many examples with the menstrual history of the patient. When the blood is poured out in large quantity, symptoms of loss of blood are present. Pain is not a constant phenomenon, but exists more or less in many cases, and is a result of the perimetritis which follows the effusion of blood into the cavity of the peritoneum. It is a remarkable feature of this disease that the tumour which forms in the abdomen often disappears so rapidly, that a swelling which was originally of large size is reduced in a few weeks to comparatively small dimensions, and, in a short time, all that can be detected is the remains of the perimetritis. The diseases with which it is most liable to be confounded are perimetritis and perimetric abscess, and, unless the case is a well-marked one, the differential diagnosis is not a simple matter. A consideration of the history of the commencement of the disease, and of its subsequent disappearance, will, in most instances, suffice to distinguish them from one another.—*Med. Times and Gaz.*, April 15, 1871.

—

Cast of the Female Bladder.—Dr. J. R. WARDELL exhibited an extraordinary pathological specimen, consisting of what seemed to be the exuviation of the entire mucous membrane of the urinary bladder, in a woman aged 28, admitted into the Tunbridge Wells Infirmary. The mass was absolutely seen to pass out of the bladder by the house-surgeon, Dr. De Havilland Hall. The following are the clinical details of the case furnished by Dr. Wardell.

M. B., aged 28, married, the mother of three children, was admitted on April 14th, 1871. On the 9th she had gone to bed apparently well. In the middle of the night she awoke up and tried to pass urine, but was unable to do so. The next day, at noon, a catheter was introduced, and the urine was drawn off. Retention continued until her admission. The secretion was fetid, and contained a large quantity of mucus. On admission, she complained of great pain over the pubic region, accompanied by straining and a constant desire to micturate, but all at-

tempts to do so were ineffectual. After she had been in the infirmary about half an hour, Dr. Hall was hastily summoned to the ward, as she had declared that something within her had "broken." On introducing the finger into the vagina, the legs of a fœtus were felt protruding, and in the course of an hour a fœtus of from three to four months was expelled. The placenta came away three hours afterwards. The patient was soon able to pass urine. During the next three or four days she had incontinence. The urine was very offensive, and contained a large quantity of mucus. Twelve days subsequently to admission, she was seized with great pain over the pubic region, which was only partially relieved by grain-doses of opium. On the morning of the 20th the house-surgeon was again hastily called to the patient. She was in excessive pain, and the cause of her suffering was ambiguous. Digital examination felt a substance being expelled; and visual inspection showed a mass of something in the process of being passed through the meatus urinarius. It was a membranous substance; it felt resisting and organized. After the lapse of half an hour, this slowly protruding mass was fully expelled. On examination, it almost seemed as if the whole of the mucous coat of the organ had been thrown off. At the moment of its expulsion the urine gushed out with great force and in large quantity. The woman from that time obtained instant relief, and continued to improve daily. She was treated with sedatives, and requested to drink large quantities of barley-water and milk and water. At the date when this case was related (May 10th) the secretion was nearly normal, and the patient was not at all troubled with a desire to micturate.

Dr. Wardell observed that he had referred to several works on pathology, but could find nothing resembling the case now narrated. He said he was confidently certain the mass passed out of the meatus urinarius, because the placenta had been thrown off in due time, and the substance, on minute inspection, had nothing of placental characteristics: it was too large, was not of the placental configuration, and not vascular, there were no tufts, and no signs of funal insertion; because on its inner surface there were gritty deposits, evidently consisting of oxalate of lime and uric acid; because Dr. Hall felt something like a foreign body when he introduced the catheter; and, above all, because the house-surgeon could not be mistaken when he said he saw it coming through the meatus. Again, there had been the common symptoms of vesical inflammation; there had been localized pain, a loss of the normal contractile power of the organ, a fetid secretion, and an abundance of stringy tenacious mucus. Dr. Wardell regarded the product as a croupous plastic exudation, just as we sometimes discover casts thrown off from the trachea, the bronchi, etc. The most remarkable feature in the case was the evident and speedy restoration of the function of the bladder. Having got rid of that which came to act like a foreign body as it were, the organ recovered its natural functions.—*Brit. Med. Journ.*, June 10, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Allopathy.—We have always and must continue to repudiate this epithet when bestowed upon scientific medicine as wholly inapplicable. It is a word invented by the homœopathists, and given to scientific medicine with the artful design of degrading the latter in the estimation of the ignorant to the level of homœopathy—a system founded upon a single idea, as are the systems of all the pathists. But scientific medicine never has been, never assumed to be, and never can be restricted to such narrow limits.

The devotees to *pathies* have their mental vision so clouded and limited by their one idea systems, that they see all things through a mist which strangely distorts them. We need not say to the scientific physician that to discern objects accurately, they must be viewed through a perfectly transparent medium—one free from all errors of refraction, and with the mind perfectly unbiased by visionary hypotheses.

Opium in the Treatment of Dysmenorrhœa.—Dr. Wm. Goodell states (*Medical Times*, April 15, 1871) that most of the forms of dysmenorrhœa are relieved during the attack by morphia, given either by the mouth or hypodermically. This could be explained by the threefold action of opium, for it is the best of narcotics, the most efficient relaxant of a rigid cervix, and an excito-motor of uterine muscular fibre—properties which meet many of the indications in dysmenorrhœa. In the congestive variety, in which the womb throbs like a headache, found usually in fat and plethoric women, chloral with hip-baths answered far better during the attack; but in the intervals the iodide of potassium, saline cathartics, and scarifications of the cervix are of great advantage. On the other hand, the effects of full doses of morphia are peculiarly happy in those nervous and neuralgic varieties of dysmenorrhœa so often met with in pale, thin, tall, and hysterical girls. The menstrual fluid accumulates in the cavity from a spasmodic closure of the internal os uteri, and escapes in gushes at such times alone as the expulsive pains overcome the resistance of such constriction. Opium is here the remedy *par excellence*, for it not only lulls the pain, but also takes away the cause of this pain by softening down and relaxing the rigid cervix.

—

Belladonna in Typhoid Fever.—Dr. Lewis S. Pilcher, Asst. Surgeon U. S. N. (*Mich. Univ. Med. Journ.*), having been attracted by the positive and warm terms in which the effects of belladonna, given in typhoid fever, are stated by Dr. B. Kelly, of Dublin, finds that under its influence, within from 24–48 hours after the first administration of the drug, delirium, coma, and subsultus quickly vanish, and are succeeded by calmness and clearness of the intellect, by natural sleep, and complete control of all the voluntary muscles. Diarrhœa is checked, and healthy, consistent evacuations are established.—*Med. Record*, June 15, 1871.

—

Hydrate of Chloral in Intermittent Fever.—Dr. F. A. Duzan, of Zionsville, Indiana, claims (*Indiana Journal of Medicine*, May, 1871) to have employed the hydrate of chloral successfully in the treatment of intermittent fever where quinia, arsenic, and other antiperiodics had failed. He gave fifteen grains five hours before the expected cold stage, and repeated the dose every hour until five doses had been taken. In one case narrated he repeated the doses on the day of the expected return, and after that there was no recurrence of the disease.

—

Rupture of the Liver without External Evidence of Violence.—Dr. T. F. Dudley records (*The Medical Archives*, March, 1871) the following case of this:—

W. B., of this city, aged 28, of good physical and muscular development, was attempting, on Feb. 9th, to "couple" two railroad cars, when the coupling bar (fastened at one end) not being so guided as to make proper connection with the approaching car, was driven round with considerable force and struck him across the upper part of the abdomen, causing intense and continued pain. Good medical and surgical attendance was procured, but nothing could be done further than to partially allay his excruciating pain with anodynes, and he died on the 11th.

Upon post-mortem examination there was found no evidence of any bruise, nor even a scratch or abrasion upon the surface, but an abdominal section revealed a large amount of blood poured out in the abdominal cavity, from a rupture of the right lobe of the liver about two inches in length. No other organ was found to be injured.

The point of interest in this case is the very serious internal and fatal injury sustained without any mark or trace of violence upon the surface.

—

Cundurango.—This is the title of a new drug lately discovered in Ecuador, a sample of which, with testimonials of its wonderful efficacy in the cure of cancer, has lately been transmitted by the American minister to that country to the U. S. Secretary of State. We have carefully read the testimonials as published in the

National Medical Journal for May last, and it appears to us that they are vague and unsatisfactory.

—

Harvard University Medical School.—We have received the 88th annual announcement (Session, 1871–72) of this school, and must congratulate the Faculty on the decided advance they propose to make in the course of instruction. The plan of study in this school is to be radically changed.

"Instruction will hereafter be given by lectures, recitations, clinical teaching, and practical exercises uniformly distributed throughout the academic year. This year begins on the Thursday following the last Wednesday in September, and ends on the last Wednesday in June; it will be divided into two equal terms with a recess of one week between them. There is also a recess of one week at Christmas. Either of these two terms will be more than equivalent to the former 'Winter Session,' as regards the amount and character of the instruction. The course of instruction has been greatly enlarged, so as to extend over three years, and has been so arranged as to carry the student progressively and systematically from one subject to another in a just and natural order.

"In the subjects of anatomy, physiology, chemistry and pathological anatomy, laboratory work will be substituted for, or added to, the usual didactic lectures. Every student will have his place and time in the anatomical, physiological, and chemical laboratories, and in the microscope room; and laboratory work will be as much required of him as attendance at lectures and recitations.

"Instead of the former hasty oral examination for the degree of Doctor of Medicine, held at the end of the three years' period of study, a series of examinations on all the main subjects of medical instruction has been arranged. These examinations will be distributed for regular students through the whole three years; but they may be passed by other students either all at once at the end of their course, or, successively, at several times. Every candidate for the degree must hereafter pass a satisfactory examination in every one of the principal departments of medical instruction at some time during his period of study. The Faculty are convinced that this requisition will present no serious obstacle whatever to those who do not neglect their opportunities.

—

The American Journal of Obstetrics, &c.—This valuable journal has changed publishers, and is now issued by Wm. Baldwin & Co., New York.

—

The Virginia Clinical Record.—This is the title of a new monthly journal, of which two numbers have recently been published by M. W. Hazlewood, Richmond, Virginia. It has our best wishes for its success, and we welcome it to our exchange list.

—

OBITUARY RECORD.—The No. of the *Virginia Clinical Record* for April announces the death of Dr. DAVID H. TUCKER, formerly Professor of the Practice of Medicine in the Medical College of Virginia. Dr. Tucker for several years was a resident of this city, where he secured many warm friends, and occupied for a time the chair of Midwifery in the late Franklin Medical College.

FOREIGN INTELLIGENCE.

Some further Additions to Therapeutics: Organic Bromides, Metachloral; with a note on Sulphur Alcohol.—Dr. RICHARDSON read before the Medical Society of London (March 18) a paper entitled as above. The author first described the methods of research in therapeutics, which consist in following up modification of certain organic compounds by modification of the elementary composition of the compound. He then introduced some new medicinal bromides, viz., bromide of quinia, bromide of morphia, and bromide of strychnia, together with combinations of the same. Bromides are best administered in the form of syrups, each drachm of the syrup containing—in the syrup of the bromide of quinia, one grain of the bromide of quinia; in the syrup of the bromide of morphia, one-eighth of a grain

of morphia; and in the syrup of the bromide of strychnia, one thirty-secondth of a grain of bromide of strychnia. Compounds of the syrups of the bromides of quinia and morphia, and of quinia, morphia, and strychnia, were also useful. In each drachm of these the same proportion of dose, viz., one grain of quinia, one-eighth of a grain of morphia, one thirty-secondth of a grain of strychnia, was maintained. Dr. Richardson had found the bromide of quinia of great service in syphilitic ulceration. He had obtained most valuable results from frequently repeated doses of syrup of bromide of quinia and morphia in cases of neuralgia; and in a case of diabetes the syrup of quinia, morphia, and strychnia had been signally successful. The bromide of quinia he believed the best preparation in cases of remittent or intermittent fever. Dr. Richardson next brought forward bromal hydrate; it was less soluble than chloral hydrate, and produced more convulsive action, and, on the whole, he did not think it could at all replace the last-named substance. He then passed on to anhydrous chloral, placing before the society a specimen of pure anhydrous chloral, and, by the addition of pure water, it produced chloral hydrate. Chloral itself is a fluid caustic; it abstracts water rapidly, and might, he thought, be usefully employed as a caustic in some cases where soft fungous growths required to be removed. Chloral hydrate absorbed would be found to exert an after sedative influence. A specimen of meta-chloral was then shown, an insoluble white substance made by exposing chloral hydrate to sulphuric acid. This substance is isomeric with chloral, and, when treated with alkali, is resolved into chloroform and chlorate of the alkali employed. Administered to inferior animals, it seemed to act as a gentle narcotic; being probably slowly decomposed in the body, it may yet prove of service in practical medicine; lastly, Dr. Richardson exhibited a specimen of mercaptan, sulphur alcohol (C_2H_6S), in which sulphur replaces the oxygen of ordinary alcohol. He detailed a number of interesting facts bearing on the action of this agent, dwelling especially on the mental depression it produces even when taken in very minute quantities. The alcohol is exhaled by the breath as it passes from the bodies of animals, and communicates to the breath peculiar odours like the odour met with in wasting diseases. From this fact the author drew a suggestion for a new line of research in diagnosis, viz., the detection of organic sulphur compounds derived from the blood in the air expired from the lungs by diseased persons. Sulphur compounds liberated in the alimentary canal seemed harmless—*i. e.*, were not absorbed—but it was now quite certain that when some of them are actually introduced into the circulation, even in minute quantities, and are diminishable by exhalation from the lungs, they produce muscular debility, feebleness of the heart, and mental depression. We may, therefore, infer that the formation of sulphur compounds within the circulation from disease might account for some examples of excessive temporary prostration, for the cause of which we have as yet no satisfactory explanation.—*Medical Times and Gazette*, April 8, 1871.

—

Neuralgia treated by the Constant Current.—Dr. Buzzard and Dr. Anstie reported cases to the Clinical Society (*Lancet*, May 20, 1871) in which this mode of treatment proved very effective. In Dr. Buzzard's case, a woman, aged 65, had suffered for three months from paroxysms of agonizing pain in the neck and right arm, which attacked her several times every hour night and day, deprived her of rest, and rendered her arm useless. The neuralgia had followed seizures which sufficiently indicated its central origin, and this, coupled with the age of the patient and the degeneration of the tissues, rendered its cure in the highest degree improbable. Applications of a sedative character had been useless in relieving her suffering. A constant current derived from ten cells (increased afterwards to fifteen cells) of a Weiss' battery was applied from time to time, between the cervical vertebræ and the hand, with the effect of producing remarkable relief to her pain, insomuch that at one time she thought herself cured.

Under the influence of this treatment the patient was enabled to sew, and to cut her food with the right hand, which had previously been so helpless that she was forced to lift it with the other. With the view of testing the effects of the application, it had been intermitted on several occasions, and other remedies, as blisters, sedatives, and tonics, had been employed, but these failed in preventing the paroxysms of pain. Summing up the results of treatment, Dr. Buzzard said that out of sixteen applications of the constant current, ten had been followed by very great and well-marked relief, two by moderate relief, and four by very slight relief. Dr. Buzzard brought the case forward, not as one of cure of neuralgia, but as a good example of the effects of the constant current in relieving pain; and he drew attention to the process because he believed it was as yet very little employed for this purpose in this country, although, as was well known, its efficacy had been perfectly recognized and insisted upon abroad for many years past. Dr. Anstie referred at the same meeting to two cases—one of severe neuralgia in the right cervico-brachialis in a married woman, aged 48; the other of double cervico-occipital neuralgia in an unmarried needlewoman, aged 30. In the former case a cure was effected; in the latter not. The constant current was employed, with a strength of ten cells, afterwards increased to fifteen; the positive pole in the first case being applied alternately on the various foci of pain, the negative pole being applied by the right side of the three lower cervical vertebræ. The pain was at once diminished, and ceased altogether at the end of thirteen days; and a secondary anæsthesia of the skin, with secondary paralysis of the deltoid and trapezius, were removed at the end of twenty-four days' treatment. The cure was found persistent six weeks later. Dr. Anstie remarked that the effect of the constant current in neuralgia was very remarkable, but that there were as yet some unexplained anomalies in its action. In the large majority of cases it acted as a palliative most strikingly. In a not inconsiderable number of cases it appeared to cure the disease absolutely; in a few examples it failed to produce any good effects. As a general rule it was far less effective in the neuralgias of old persons with degenerated tissues than in younger subjects; but occasionally even a young person, like the second of his cases, fails to derive benefit from it.—*The Practitioner*, June, 1871.

—

Treatment of Obstinate Vomiting by Iodine.—In cases in which obstinate vomiting occurs after the administration of aperients, Caspar and Bierbaumb have found that the administration of iodine as recommended by Rademacher has been followed by excellent results. Thirty drops of the tincture of iodine, with a scruple of tragacanth, are added to eight ounces of water, and of this mixture a tablespoonful is to be taken every hour. These observers have found that gastric pain as well as vomiting subsides under the use of this remedy.—*Dublin Quart. Journ. of Med. Sci.*, May, 1871.

—

The Nature of the Intestinal Lesion of Enteric Fever.—Dr. T. J. MACLAGAN, in a paper on this subject, read before the Medico-Chirurgical Society of Edinburgh (*Edin. Med. Journ.*, April, 1871), summarizes his views as follows:—

1. The intestinal lesion of enteric fever is specific in character.

2. It may terminate in resolution or ulceration.

3. When it goes on to ulceration there are two sets of lesions, primary and secondary.

4. The former are an essential part of the disease.

5. The latter are accidental, and the result of the inoculation of healthy glands by discharges coming from the former.

6. The recognition of these two forms of lesion is necessary to the explanation of the diverse phenomena of the disease.

7. Their relative frequency varies in different cases.

8. The extent of the primary lesions bears a direct relation to the severity of the attack.

9. That of the secondary bears no such relation, they being more likely to pre-

dominate in cases in which the general symptoms are mild, and the primary lesions few.

10. One primary lesion is sufficient to produce, directly or indirectly, many secondary.

11. The discharges do not necessarily inoculate every gland over which they pass.

12. The longer they remain in contact with a gland, the more likely is it to suffer.

13. The higher up in the intestine the primary lesions are situated, the more numerous, *cæteris paribus*, will be the secondary.

14. Fatal abdominal symptoms are more often the result of secondary than of primary lesions.

15. Relapses are caused by a reabsorption of the poison into the system, probably by one or more absorbent glands which escaped during the primary attack.

16. Constipation is to be regarded as a source of ultimate danger.

17. No one suffering from enteric fever should go more than two days without a stool.

—

Gastrotomy for Internal Intestinal Obstruction.—Mr. Thomas Annandale, in some remarks (*Edin. Med. Journ.*, Feb. 1871) on this operation, arrives at the following conclusions:—

1. That when the symptoms of sudden and complete intestinal obstruction are present, and the ordinary means of treatment have failed to give relief, the operation of gastrotomy is justifiable and advisable.

2. That the operation should not, if possible, be delayed beyond forty-eight or thirty-six hours after the first symptoms have appeared.

3. That the abdomen should be opened in the middle line; and that, during the operation and after it, every precaution should be taken to lessen the risks of peritonitis.

4. That when the abdominal cavity is opened, the best guide to the seat of obstruction is the contracted or dilated condition of a portion of the intestine.

5. That, if the intestine be gangrenous, or the obstruction not removable, its canal should be opened as near the obstruction as possible, and an artificial anus established.

—

Fatal Result from the Intra-Uterine Injection of a Solution of the Sesquichloride of Iron.—Dr. Kern reports (*Würtemberg Med. Corresp. Blätter, No.* 7, 1870) a case of uterine hemorrhage after four successive conceptions and abortions, in a thin, weak, anæmic, and somewhat rachitic woman of thirty-six years of age. Various styptics were employed, among others an injection of a drachm of the liquor ferri sesquichlorati in ten ounces of chamomile water. A third injection of this solution, further diluted with tepid water, was very painful, induced uterine colic, followed next day by veritable metroperitonitis, which terminated fatally, thirty hours after the injection, in spite of the most appropriate treatment, such as leeches, cataplasms, ice, cold enemas, opium internally and subcutaneously, etc.—*Med. Record*, May 15, 1871.

—

Raw Meat.—The use of raw meat in the treatment of disease is objected to by Mr. M. R. Levi (*Giornale Veneto*), unless the said meat be other than that of the ox or the pig. He recommends the use of chicken, pigeon, or turkey meat for this purpose, as the others are apt to produce the tænia.—*Med. Record*, June 15, 1871.

—

Ought Consumptives to Marry.—Dr. Robert Barnes maintains that the problem—Is it to the advantage of the community, or of the individuals primarily concerned, that those bearing the seeds of tubercular phthisis should marry?—is one which medical science may properly discuss.

My own observation tells strongly on the negative or prohibitory side.

1. I have now seen a good many very sad instances where young men and women in whom consumption was either latent, stationary, or slowly progressing, have sunk rapidly after being "engaged," or after being married. The chance of recovery, or even of not getting worse, of a tuberculous sufferer, depends upon observing the strictest hygienic rules; and of

these rules a main one is the preservation of mental and emotional calm.

2. I have seen the effect of pregnancy and labour upon many consumptive women. I have no hesitation in saying that there never was a greater fallacy than that which affirms that pregnancy is antagonistic to phthisis. In my experience, labour commonly precipitates the fatal issue of the disease. Some perish during pregnancy; a large number sink rapidly after labour. This last trial breaks down the remaining forces of the system.

3. Consumptive people seem at least as apt in procreation as others. The children whom they bring into the world undoubtedly inherit the tubercular diathesis. How many of these perish quickly of convulsions, or, a little later, of abdominal or pulmonary disease! How few grow up to robust adolescence! And how large a proportion of those who survive to maturity repeat the sad history of their parents, scattering mental and physical distress around them!—*Brit. Med. Journ.*, Feb. 25, 1871.

—

Pathology of Phthisis.—Dr. E. Aufrecht (*Berlin Klin. Wochenschrift*) summarizes 100 cases of tuberculosis (in Laennec's sense of the word) with the *post-mortem* appearances. The lungs were affected in ninety-two of the cases, and alone affected in forty-eight. In none of these forty-eight cases was any trace of true tubercle found. For these cases, therefore, Aufrecht recommends the designation cheesy broncho-pneumonia, except in those instances where a whole lobe is affected at once. Besides these forty-eight, in two others there was ulceration of the larynx, and in fourteen ulceration of the bowel, but in none of the sixteen was tubercle found. In other twenty-four cases the broncho-pneumonia was associated with actual tubercles, viz., four times on the pleura, and four times on the peritoneal covering of the bowel, whilst in sixteen they were found in various organs; only seven times, however, in the lungs themselves. In the remaining four cases of the ninety-two, the lungs were affected with tubercle only; other organs, however, being simultaneously involved. The author concludes that "The disease of the apices or upper lobes of the lungs, whether for a longer or shorter time confined to these, and known under the name of phthisis, never begins with the formation of tubercles, but always in the form of broncho-pneumonic accumulations. In this form the affection can run its course from beginning to end, the cheesy broncho-pneumonia being only in the minority of cases complicated by tuberculosis."—*Med. Press and Circ.*, May 31, 1871.

—

Typhoid Fever with Constipation.—Dr. Murchison exhibited to the Pathological Society of London (*Lancet*, May 20, 1871) a specimen of typhoid ulceration of the intestine from the body of a man who had died suddenly from fatal hemorrhage into the intestine on the twenty-seventh day of the disease, and in whom there had been constipation. He brought forward the case—not a very unusual one—to disprove the common notion that continued fever with constipation is typhus, and with diarrhœa, typhoid fever. The case presented numerous other interesting clinical features.

—

Dislocation of the Hip.—Dr. Eben Watson reports (*Glasgow Med. Journ.*, May, 1871) that four cases of this were treated by him at the Glasgow Royal Infirmary. "In all cases," he says, "the head of the bone was on the dorsum ilii, and in all it was easily reduced by manipulation. I know of no operation which a surgeon performs with greater pleasure to himself or benefit to his patient than this new or revived method of reducing dislocations of the hip, for which we are indebted to our American brethren. In some of my cases the dislocation was of old standing, and yet neither ropes nor pulleys were required."

—

New Fluid for the Preservation of Microscopic Preparations.—Max Schultze, in the last part of his *Archiv für Mikroscop. Anatomie*, observes that of all fluids now in use for the preservation of microscopical specimens, glycerine, either pure or mixed with other reagents, is most widely employed. This substance, though possessing the peculiarity of rendering many

tissues transparent, yet unites with fats, and so modifies the differences of refraction occasioned by the presence of fat. Since the introduction of perosmic acid a new disadvantage attaches to glycerine—namely, that if the least trace of the acid remains, the glycerine becomes black, especially around the preparation, and there are no means of removing perosmic acid completely; washing, even when continued for days, being inefficient. Under these circumstances, M. Schultze has been engaged in seeking for a fluid which might replace glycerine, and has, he thinks, discovered one in a nearly concentrated watery solution of *acetate of potash*. According to Dippel, through whose work Schultze first became acquainted with it, it was originally employed by Sanio for the investigation of vegetable structures in place of chloride of calcium; and Dippel found it serviceable also for preserving animal tissues. Schultze applied the fluid in the same way as glycerine, a drop being allowed to flow over the specimen after it has been prepared in water or serum, without raising the cover. After the lapse of twenty-four hours the preparation is luted down. As the fluid neither dries up nor crystallizes out, the specimens may be long preserved in it. M. Schultze states that the solution has now been in use for two years in his laboratory, and no disadvantages have been found to attach to it, whilst it possesses all the advantages of glycerine.—*Lancet*, March 25, 1871.

—

Cholera in Madagascar and along the Southeast Coast of Africa.—It is stated that cholera prevails to a considerable extent along the east coast of Madagascar, in the islands Mayota and Johanna (members of the Comoro group), at the northern extremity of the Mozambique Channel, and along the east coast of Africa, to the south of Port Mozambique, between the eighteenth and nineteenth degrees of latitude, about the mouths of the Zambesi River. The gradual extension of cholera in a southerly direction from Zanzibar, along the coast-line, towards the Cape Colony, is a subject of extreme importance, and suggests great difficulties in the establishment of the theory, supported by Inspector-General Lawson, of the advance of this disease by "pandemic waves" from south to north, along the belts inclosed by the isoclinal lines of terrestrial magnetic influence.—*Med. Times and Gaz.*, June 10, 1871.

—

Alkaloid detected by Picric Acid.—Mr. Hager has found that this acid precipitates various alkaloids from their solutions, such as brucine, strychnine, veratrine, quinine, cinchonine, and some alkaloids of opium. Morphine and atropine, however, are precipitated only from neutral and concentrated solutions; but the precipitate dissolves pretty easily in water. Glucosides, caseine, and pseudomorphine resist the action of the picric acid.—*Lancet*, June 10, 1871.

—

Deaths from Chloroform.—The *British Medical Journal* for April 22 announces two cases of this, and the *Lancet* for May 20th, a third.

—

Von Graefe's Successor.—Prof. Schweigger, a pupil of the late eminent ophthalmologist, has just been appointed to succeed Graefe at the Charité Hospital of Berlin. Dr. Schweigger had hitherto occupied a chair in Zurich.—*Lancet*, May 20, 1871.

—

Oppolzer's Successor.—Dr. H. Bamberger, at present Professor at Würtzburg, has been chosen to fill the chair rendered vacant by the death of Professor Oppolzer.

—

Smallpox.—The number of deaths in London for the weeks ending May 6, 13, 20, and 27, were respectively as follows: 288, 232, 267, 257. The smallpox epidemic in London shows but little signs of decrease.

—

Obituary Record.—M. Longet, the eminent physiologist, has just died at Bordeaux, aged sixty-eight. M. Longet was member of the French Institute, and of the French Academy of Medicine. His death, which was sudden, is ascribed by his friends to shock produced by the deplorable news from Paris.

BLANDFORD ON INSANITY—Just Issued.

INSANITY AND ITS TREATMENT:

LECTURES ON THE TREATMENT, MEDICAL AND LEGAL, OF INSANE PATIENTS.

By G. FIELDING BLANDFORD, M. D.,

Lecturer on Psychological Medicine at the School of St. George's Hospital, London.

WITH A SUMMARY OF THE LAWS IN FORCE IN THE UNITED STATES ON THE CONFINEMENT OF THE INSANE.

By ISAAC RAY, M. D.

In one very handsome octavo volume of 471 pages: extra cloth, **$3 25.**

This volume is presented to meet the want, so frequently expressed, of a comprehensive treatise, in moderate compass, on the pathology, diagnosis, and treatment of insanity. To render it of more value to the practitioner in this country, an appendix has been added by Dr. Isaac Ray, giving a synopsis of the laws of the several States of the Union on the confinement of the insane, thus affording information not elsewhere to be found in so accessible a form, to physicians who may at any moment be called upon to take action in relation to patients.

The value of the work to the profession in the United States is enhanced by the Appendix, which furnishes a summary of the laws in force in all the States. If we were asked to name the most useful volume on insanity, for the purposes of the student and general practitioner, we should unhesitatingly give our preference to that of Dr. Blandford.—*N. Y. Med. Record*, June, 1871.

We are glad to welcome this treatise, and commend it, not only to medical men in general and those of our specialty, but to the members of the legal profession, as a book which cannot fail to be alike useful to all.—*American Journal of Insanity*, April, 1871.

A cordial welcome is due to Dr. Blandford's book, as being a most grateful addition to the literature of psychological medicine. We can assure every one that most valuable hints may be obtained from it when called upon to treat insanity or to take reluctant steps for placing insane patients under legal restraint. The Appendix, by Dr. Ray, supplies a positive want, and is a happy thought.—*Philadelphia Medical Times*, May 15, 1871.

Dr. Blandford's work is the latest and most practical on the subject.—*N. Y. Med. Gazette*, June 5, 1871.

The student or miscellaneous reader, who would pick up with little labor a clear and general idea of the subject of insanity in nearly all its bearings, will find this book better adapted to his purpose than any other that we know of. It is as lively as a novel in its style, and at the same time eminently practical. We hail it as a valuable acquisition to a department of medical science, the interest and magnitude of which increase every day.—*Pacific Med. and Surgical Journal*, June, 1871.

This book supplies a want much felt in this department of medical literature. No disease of equal frequency and gravity has been so imperfectly studied as insanity, and most works on this subject are too voluminous for the busy practitioner, who needs a concise manual for occasional reference, rather than an elaborate essay on the subject, and the work well meets the prevailing deficiency.—*Canada Lancet*, June, 1871.

Many points which our space will not permit us to notice, well deserve our attention. We must be content to recommend the work to the practitioner, with full assurance that in the careful study of it he will be repaid, as regards time and money.—*Indiana Journal of Medicine*, May, 1871.

We end as we began, in heartily recommending it as a most useful and reliable guide for the general practitioner. The synopsis of the laws in the different States of the Union, added in the American edition, will supply a want much felt by the practising physician.—*Am. Journ. Med. Sciences*, April, 1871.

SECOND EDITION—Lately Published.

ESSENTIALS OF THE PRINCIPLES AND PRACTICE OF MEDICINE

By HENRY HARTSHORNE, M.D.,

Professor of Hygiene in the University of Pennsylvania, &c.

SECOND EDITION, REVISED AND IMPROVED.

In one handsome royal 12mo. vol. of 452 pages, clearly printed on small type: cloth, **$2 38**; *half bound,* **$2 63.**

Truly a *handy* book—the most so of any in our library, and the one we would least like to part with if unable to replace it.—*Northwestern Med. and Surg. Journal*, July, 1870.

If used as a hand-book only, it will commend itself as the best we have yet seen. The style is clear, the most important points of practice well delineated, and its size such as to be conveniently carried.—*Am. Journ. of Obstetrics*, Aug. 1869.

The author has been at great pains to collate the materials for this book. The sifting process has been judiciously performed, and the power of condensation has been carried to the utmost. For practical purposes, such books are no doubt very useful, although not altogether free from objection.—*London Lancet*, June 19, 1869.

It is as well arranged, full, practical, and useful as any treatise can be, having so wide a scope and such limited space.—*Buffalo Med. and Surg. Journal*, March, 1869.

This is one of the handiest books with which we are acquainted. To the student of medicine in attendance upon lectures it will be found invaluable, and to the practitioner it will be found most convenient.—*Cincinnati Med. Repertory*, March, 1869.

This is a small sized octavo of 452 pages, containing an admirably condensed summary of the principles and practice of medicine. We do not hesitate to say that this work of Dr. Hartshorne is the very best of its kind.—*Chicago Med. Examiner*, March, 1869.

HENRY C. LEA, Philadelphia.